STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155486	A. BUILDING **02** B. WING _____	R **12/10/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDDLETOWN NURSING AND REHABILITATION CENTER	**131 S 10TH ST** **MIDDLETOWN, IN 47356**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/28/13 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/10/13 Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600 Surveyor: Mark Caraher, Life Safety Code Specialist At this PSR survey, Middletown Nursing and Rehabilitation Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consisted of the South Wing, a one story wing determined to be of Type V (111) construction and fully sprinklered, and the North Wing, a one story wing determined to be Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridor. The facility has battery operated smoke detectors installed in the twelve resident rooms on the North Wing and hard wired smoke detectors in the fifteen resident rooms on the South Wing which are electrically wired to an audible signal at the nurses' station. The facility	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 000}	Continued From page 1 has a capacity of 45 and had a census of 22 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/12/13.	{K 000}		